

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6763

CERTIFICATE OF DEATH

06743

Reg. Dist. No. 260.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b 86 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First X John	Middle X Upshur	Last Anderson	4. DATE OF DEATH	Month June	Day 24	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH Oct. 20, 1870	9. AGE (In years lost birthday) 86 yrs.	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Anderson		14. MOTHER'S MAIDEN NAME Sarah Lankford						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mr. S.H. Anderson		Address Princess Anne, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute See 7 heart trouble</i> 16 days 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic but regularly chronic hypertension</i> years DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hyper tension arteriosclerosis</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No injury		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No						
20c. TIME OF INJURY Month, Day, Year Hour a. m. no injury 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Maryland	(County) Maryland (State) Md.	
21. I certify that I attended the deceased from June 1 , 1957, to June 24 , 1957, that I last saw the deceased alive on June 24 , 1957, and that death occurred at 7 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland DATE SIGNED George C. Coulbourn M.D.								
ACTUAL SIGNATURE George C. Coulbourn M.D.								
PHYSICIAN'S NAME (Type) George C. Coulbourn M.D.		22c. NAME OF CEMETERY OR CREMATORIUM St. Andrew Cemetery		22d. LOCATION (City, town, or county) (State) Princess Anne, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-27-57		22d. LOCATION (City, town, or county) (State) Princess Anne, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Levin D. Wilson		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR JUN 28 1957		24b. REGISTRAR'S SIGNATURE G. J. Thompson		

CERTIFICATE OF DEATH

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BUREAU V. S.

JUN 28 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6764

CERTIFICATE OF DEATH

06741

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden		c. LENGTH OF STAY IN 1b 77 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Coulbourn		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX male		6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1879	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Arrick Barkley				14. MOTHER'S MAIDEN NAME Esther Graham				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ada Barkley Eden, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 2 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fruitland, Md.		(County)	(State)	
21. I certify that I attended the deceased from Jan , 19 51 , to Jan , 19 51 , that I last saw the deceased alive on 6-15-57 , 19 51 , and that death occurred at Fruitland, Md. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fruitland, Md.								
DATE SIGNED Lee L. Lawry								
ACTUAL SIGNATURE Lee L. Lawry								
PHYSICIAN'S NAME (Type) Lee L. Lawry		M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-19-57		22c. NAME OF CEMETERY OR CREMATORIAL Flowers Hill Cemetery		22d. LOCATION (City, town, or county) Eden, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Levin Wilson Princess Anne, Md.								
ADDRESS Levin Wilson Princess Anne, Md.								
24a. REC'D BY REGISTRAR JUN 24 1951								
24b. REGISTRAR'S SIGNATURE Dr. R. H. Johnson								

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tylerton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCready Hospital			d. STREET ADDRESS Smith Island			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First JOHN	Middle LEWIS	Last BRADSHAW	4. DATE OF DEATH June 21	Month Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1875	9. AGE (In years from birth) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Crab & Oyster		11. BIRTHPLACE (State or foreign country) Tylerton, Maryland		
13. FATHER'S NAME John Bradshaw			14. MOTHER'S MAIDEN NAME Ellen Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT George Delmas Bradshaw--Tylerton, Md.		
Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181X DUE TO Carcinoma, bladder						INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1953 to June 1957, that I last saw the deceased alive on June 21, 1957, and that death occurred at 4:30 A. M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE Dr. C. G. Rawley M.D.						DATE SIGNED 6/22/57
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 23, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Tylerton Cemetery	22d. LOCATION (City, town, or county) Tylerton, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.			ADDRESS	24a. REC'D BY REGISTRAR DATE 6/22/57	24b. REGISTRAR'S SIGNATURE Barbara S. Adams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V.

JUN 25 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 Item 18 Film 219 9-4-57 A105 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6766 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Sussex</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deer Island</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>00</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catoctinville</i>	
f. STREET ADDRESS <i>1310 Rice Ave</i>		d. STREET ADDRESS <i>1310 Rice Ave</i>	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sylvia</i>		First <i>Marie</i>	Middle <i>Cooke</i>
4. DATE OF DEATH <i>June 25, 1957</i>		Last <i>June</i>	Month <i>June</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. STATE OF BIRTH <i>Pennsylvania</i>		9. AGE (in years last birthday) <i>18 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i></i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Bert Shutt</i>		14. MOTHER'S MARRIED NAME <i>Amy Ecker</i>	
15. WAS EVER IN U. S. ARMED FORCES? (Yes, no, if known) <i>No</i>		16. SOCIAL SECURITY NO. <i>17. INFORMANT</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia - Micrococcus (Staphylococcus) varians</i>		Address <i>But Shutt 1303 Rice Ave</i>	
DUE TO <i>049.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>at the date - probably Botulism</i>			
DUE TO <i>(b) Probably due to Food Poisoning</i>			
(c) <i>Fecal report to be read after autopsy -</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED <i>June 5, 1957</i>	
ACTUAL SIGNATURE <i>R.H. Johnson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>R.H. Johnson</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-8-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>MOUNT OLIVET CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>HANOVER PENN.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Farley Funeral Home - Catoctinville, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>6-5-57</i>		24b. REGISTRAR'S SIGNATURE <i>R. Johnson</i>	

RECEIVED EXAMINER-CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

JUN 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06747

Reg. Dist. No. 265

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Somerset			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 39		b. COUNTY Somerset			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Franklin Lane			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				
d. STREET ADDRESS 1 Franklin Lane			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) SUSIE		First ELIZABETH	Middle GERDNER	4. DATE OF DEATH June 20, 1957	Month Day Year 1957		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 17, 1906	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Garment Mfg.		11. BIRTHPLACE (State or foreign country) Marumsco, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Price			14. MOTHER'S MAIDEN NAME Maggie Ennis				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Arthur Gardner, Crisfield, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Mitral Stenosis, Rheumatic heart disease (c) INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) H34.3						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crisfield	(County)	(State)
21. I certify that I attended the deceased from <u>Nov</u> , 1946 to <u>June</u> , 1957 that I last saw the deceased alive on <u>June 18</u> , 1957, and that death occurred at <u>Crisfield</u> , Md., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crisfield, Md.							
ACTUAL SIGNATURE C. G. Rawley	M.D.			DATE SIGNED 6/23/57			
PHYSICIAN'S NAME (Type) C. G. Rawley, M. D.	Crisfield, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/23/57	22c. NAME OF CEMETERY OR CREMATORIUM Rehobeth Baptist Cem.	22d. LOCATION (City, town, or county) Rehobeth, Md.			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.			ADDRESS	24a. REC'D BY REGISTRAR DATE 6/23/57	24b. REGISTRAR'S SIGNATURE Barbara S. Lewis		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

BUREAU V. S.

JUN 25 1957

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G217, 7/8/57 fax

CERTIFICATE OF DEATH

06748
Reg. Dist. No. 265

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Somerset MARYLAND		o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Crisfield		Life time	
39		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
McCreedy Memorial Hospital		302 Maryland Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Ida	Middle M.
4. DATE OF DEATH		Month June	Day 27
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male Colored		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
			May 30,
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Domestic		Private home	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Crisfield, Maryland		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Jones		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
217-05-5030		Otto Handy, 302 Maryland Ave., Crisfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute dilatation Heart 443X	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		2 to 6 years.	
DUE TO (b)		Hypertension, arteriosclerotic heart disease	
DUE TO (c)		years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 4, 1957</u> to <u>June</u> , 1957, that I last saw the deceased alive on <u>June 27, 1957</u> , and that death occurred at <u>54</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Crisfield, Md.</u> DATE SIGNED <u>6/29/57</u>	
ACTUAL SIGNATURE <u>C. G. Rawley</u>		M.D.	
PHYSICIAN'S NAME (Type)		Main St.—Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Lawsonia Cemetery		22d. LOCATION (City, town, or county) Crisfield, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Harvey Bradshaw, Crisfield, Md.</u>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE <u>6/29/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bethany S. Adams</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUL 2 1957

REGGAE IN ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06749
 Reg. Dist. No. 260

6768

1. PLACE OF DEATH a. COUNTY Somerset			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE So. Carolina b. COUNTY Bamberg		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Govan 77 x - 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----			d. STREET ADDRESS -----		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					

3. NAME OF DECEASED (Type or print)	First Ronnie	Middle Lee	Last Hudson	4. DATE OF DEATH	Month 6	Day 12	Year 1957
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S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1957	9. AGE (In years from birthday) yrs. 16	IF UNDER 1 YEAR Months 16	IF UNDER 24 HRS. Hours 16
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) South Carolina	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Horace Hudson	14. MOTHER'S MAIDEN NAME Mary Kears
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Horace Hudson	Address Westover, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		INTERVAL BETWEEN ONSET AND DEATH 4 days
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0 Acute Diarrhea - child was ill		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Stooly in South Carolina - was seen by a doctor 6-11-57 then came out as mangled - child died type		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) nothing else		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Princess Anne	(County) md

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>R. H. Johnson</i>	DATE SIGNED <i>June 12-57</i>	
EXAMINER'S NAME (Type) R. H. Johnson	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/12/57	22c. NAME OF CEMETERY OR CREMATORIUM John Wesley	22d. LOCATION (City, town, or county) Princess Anne	(State) md
23. FUNERAL DIRECTOR'S SIGNATURE <i>William H. Jones</i>	ADDRESS <i>Princess Anne Md</i>	24a. REC'D BY REGISTRAR DATE 6/13/57	24b. REGISTRAR'S SIGNATURE <i>R. H. Johnson, M.D.</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V.

JUN 14 1957

РЕГЕИВЕД

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6769

CERTIFICATE OF DEATH

Reg. Dist. No.

06750
260

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE	
Somerset MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin, W. Va.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin xo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Katie	Middle Maddox	4. DATE OF DEATH Month June 21 Year 1957
5. SEX Fe	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1883
9. AGE (In years lost birthday) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	11. KIND OF BUSINESS OR INDUSTRY —	12. BIRTHPLACE (State or foreign country) Manokin
13. FATHER'S NAME John Ward	14. MOTHER'S MAIDEN NAME Harriett Horsey	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	
16. SOCIAL SECURITY NO.		17. INFORMANT None Mrs. Mary Bolar	Address 827 St. Caroline St. Baltimore Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 448X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 20, 1957</u> to <u>June 21, 1957</u> , that I last saw the deceased alive on <u>June 20, 1957</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Eldon G. Marthoman, M.D.</u> ADDRESS (Street, city or town, state) <u>Princess Anne, Md.</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/24/1957	22c. NAME OF CEMETERY Samuel Wesley
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward		ADDRESS Marion Sta., Md.	24a. REC'D BY REGISTRAR DATE 6/26/57
			24b. REGISTRAR'S SIGNATURE R. S. Johnson, M.D. (GT)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

JUN 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6761

CERTIFICATE OF DEATH

06751

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lawsonia		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield	
3. NAME OF DECEASED (Type or print) First GEORGE		d. STREET ADDRESS 1 Lawsonia	
4. DATE OF DEATH June 22,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 14, 1874	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Mister		14. MOTHER'S MAIDEN NAME Anna Byrd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-03-4357	
17. INFORMANT Mrs. Carl Blueford, Crisfield, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 <i>Arteriosclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 m.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 26, 1957</i> , to <i>June 22, 1957</i> , that I last saw the deceased alive on <i>April 28, 1957</i> , and that death occurred at <i>12 N M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Sarah M. Peyton</i> M.D. <i>334.2.2. - Engell, Ed June 27</i> PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/57	
22c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		24a. REC'D BY REGISTRAR DATE <i>6/28/57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Bradshaw & Sons</i>	

A heavily redacted document page with faint background text and several redaction boxes. The word "RECEIVED" is stamped at the bottom left, and the date "JUL 2 1957" is stamped below it. The word "BUREAU" is stamped at the top left, and "NY" is stamped to its right.

BUREAU V.

JUL 2 1957

REGELV EDC BUREAU

1 Item 20 Film 217 6-28-57 a.m.s MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6762 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06752
285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Dist Columbia b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b few days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47X-3					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Waterfront			d. STREET ADDRESS 652 Eye St., S. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First AMOS	Middle RAYMOND	Last RICKMAN	4. DATE OF DEATH June 9, 1957	Month 19	Day 19	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 25, 1901	9. AGE (in years last birthday) 55 yrs.	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman			10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) St. John's Stuart, Va			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Rickman				14. MOTHER'S MAIDEN NAME Virginia Rorer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wallace Rickman, Springfield, Virginia		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>850X</u> <u>Accidental Drowning</u> - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fell in water</u> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. His boat was tied to wharf in Hoptown section Crisfield, Md.									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hoptown Wharf	20f. (City or town) Crisfield	(County) Som	(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> M. H. Coulbourn, M. D.									
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/14/57					
EXAMINER'S NAME (Type) William H. Coulbourn, M. D.		Crisfield, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/57		22c. NAME OF CEMETERY OR CREMATORIAL Columbia Gardens		22d. LOCATION (City, town, or county) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 17 1957		24b. REGISTRAR'S SIGNATURE Barbara Adams			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

JUN 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

06753
260

Reg. Dist. No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
6770											
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)									
Somerset		a. STATE Colorado b. COUNTY —									
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beaumont R.F.D.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meeker Rural 44X-3							
Highway 13 - Somerset Co.		0		d. STREET ADDRESS Wilson Creek Route							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Warren T. Roberts				June	7			1957			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. CITIZEN OF WHAT COUNTRY?		
Male		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug 19-1937	19 yrs.				U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)							
Nut Grower				Colorado							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
C. A. Roberts		Ruth Robert									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address							
X at present time				U. S. N. S. Zepal His Chichibogolla							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Fractured skull									
815X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)	Compound fracture left forearm								
		DUE TO (c)	Fracture both Femurs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
Motor accident on Highway 13											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
		Killed Motorcycle - Hit on Chest with car.									
20c. TIME OF INJURY Hour		Month, Day, Year	20d. INJURY While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
10:00 p. m.		6-7 1952	Not while at work <input type="checkbox"/>	Highway 13 Beaumont R.F.D. Somerset Co. MD							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE		DATE SIGNED									
R. H. Johnson		June 8 1957									
EXAMINER'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)				
U.S. NAVY											
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS									
Ed. D. J. D.											
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE									
6-8-57		R. H. Johnson									
VS. A15ME(5) 5M 9/55											

REGIMENTAL MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
BUREAU V. S.
JUN 12 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06754
6771 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY SOMERSET		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VENTON		c. LENGTH OF STAY IN 1b 43 YEARS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET			
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VENTON					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DALLAS		First	Middle	Last	4. DATE OF DEATH ROYSTER	Month 6	Day 7	Year 1957			
5. SEX male		6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1913	9. AGE (In years last birthday) 43 yrs.	10. UNDER 1 YEAR Months 0	11. UNDER 24 HRS. Days 0	12. UNDER 24 HRS. Hours 0	13. UNDER 24 HRS. Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor		10b. KIND OF BUSINESS OR INDUSTRY C. A. SWANSON AND CO. PHILA. PA.		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME WILLIAM ROYSTER		14. MOTHER'S MAIDEN NAME DAISY JONES									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-05-8853		17. INFORMANT BERNICE ROYSTER. VENTON, MD.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Heart Disease INTERVAL BETWEEN ONSET AND DEATH seconds											
DUE TO 420.1											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____											
DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) VENTON		(County) MARYLAND	(State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <i>R. H. Johnson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED June 10, 1957	
EXAMINER'S NAME (Type) R. H. Johnson		22b. DATE THEREOF 6/11/57		22c. NAME OF CEMETERY OR CREMATORIUM GRACE		22d. LOCATION (City, town, or county) VENTON		(State) MARYLAND			
22e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22f. DATE THEREOF 6/11/57		22g. NAME OF CEMETERY OR CREMATORIUM GRACE		22h. LOCATION (City, town, or county) VENTON		(State) MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR. PRINCESS ANNE MD						24a. REC'D BY REGISTRAR 6-10-57		24b. REGISTRAR'S SIGNATURE R. H. Johnson M.D.			

WISCONSIN STATE BOARD OF HEALTH - DIVISION OF
MEDICAL EXAMINERS CERTIFICATE OF DEATH

WISCONSIN

STATE OF

WISCONSIN

BUREAU V. 8

JUN 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06755
Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <i>Somerset</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>New York</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rehoboth R.F.D.</i>		c. LENGTH OF STAY IN 1b <i>0</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Highway 13—Somerset Co.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Norman F. Russell</i>		First <i>N</i>	Middle <i>F</i>
4. DATE OF DEATH <i>June 7 1957</i>		Month <i>June</i>	Day <i>7</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>April 7 1934</i>		9. AGE (in years last birthday) <i>18 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School boy</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) <i>New York</i></i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Gordon Willard Russell</i>	
14. MOTHER'S MAIDEN NAME <i>Chelvinized Thomas</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Y</i>	
16. SOCIAL SECURITY NO. <i>U.S. N. 541 218 0000</i>		17. INFORMANT <i>U.S. N. 541 218 0000</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>815X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Broken neck. Fracture of left leg.</i>		DUE TO (b) <i>Blk leg. Fracture right leg.</i>	
DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>0</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <i>Motorcycle - Car accident Highway 13</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Head on collision. Car died</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Head on collision. Car died</i>	
20c. TIME OF INJURY Hour <i>10:58 p.m.</i>		Month, Day, Year <i>June 7 1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>At highway 13 - Rehoboth R.F.D. Somerset Co.</i>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>At highway 13 - Rehoboth R.F.D. Somerset Co.</i>		20f. (City or town) <i>Rehoboth</i>	(County) <i>Somerset</i>
20g. (State) <i>MD</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>R. H. Johnson</i>		DATE SIGNED <i>June 8-1957</i>	
EXAMINER'S NAME (Type) <i>R. H. Johnson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>U.S. NAVY</i>		22b. DATE THEREOF <i>ADDRESS</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>U.S. NAVY</i>		22d. LOCATION (City, town, or county) <i>(State)</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>2nd May</i>		24a. REC'D BY REGISTRAR DATE <i>6-8-57</i>	
		24b. REGISTRAR'S SIGNATURE <i>R. H. Johnson M.R.</i>	

WEDDING EXAMINEE & CERTIFICATE OF DEATH
WEDDING STATE-DEPARTMENT OF THE U.S. GOVERNMENT

RECEIVED
BUREAU V. S.
JUN 12 1957

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transfer permit.

VS A15C 1-55 10M

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06756

6773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>SOMERSET</u>		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)	
TOWN <u>DEAL ISLAND</u>		LIFE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
AT HOME		1 MAIN RD	
3. NAME OF DECEASED (First) <u>JAMES</u> (Middle) <u>WATERS</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH <u>JUNE 2 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4/6/1882</u>
106. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired.</u>	11. BIRTHPLACE (State or foreign country) <u>DEAL ISLAND MD</u>	9. AGE last birthday <u>74</u> yrs.
13. FATHER'S NAME <u>HENRY WATERS</u>	14. MOTHER'S MAIDEN NAME <u>CHARLOTTE STRONG</u>	12. CITIZEN OF WHAT COUNTRY? <u>45th</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) <u>No</u>	16. SOCIAL SECURITY NO. <u>211-16-9041</u>	17. INFORMANT & ADDRESS <u>ADDIE WATERS - wife</u>	18. MEDICAL CERTIFICATION <u>Marked Cachexia</u>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>177X</u> IMMEDIATE CAUSE (A) <u>Marked Cachexia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <u>Adenocarcinoma of prostate</u>		26 months	
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4-21-57</u> , 19 <u>1957</u> , to <u>6-2-57</u> , 19 <u>1957</u> , that I last saw the deceased alive on <u>6-2-57</u> , 19 <u>1957</u> , and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above. SIGNATURE <u>Everett C. Sutton</u> DATE SIGNED <u>6-4-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/5/57</u>	NAME OF CEMETERY OR CREMATORIAL <u>John Wesley Cemetery</u>
24. REC'D BY REGISTRAR DATE <u>6/10/57</u>		REGISTRAR'S SIGNATURE <u>Lola Wheatley</u>	LOCATION (City, town, or county) <u>Deal Island MD</u>
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			

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EXERCISES

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Notes on the Mating Habits

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